TESTIMONY OF
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Introduction

Chairman Tiberi, distinguished Members of the subcommittee, thank you for inviting me here today to discuss the reauthorization of the Older Americans Act. I am honored to have been invited to testify about how South Carolina is building the future by positioning for the senior boom. I am André Bauer, the Lieutenant Governor of South Carolina, and since July 1, 2004, head of the State Unit on Aging, the Lt. Governor's Office on Aging.

I'd like to share a few stories, beginning with the "elder-ready" community of Chesnee, which is located in eastern Spartanburg County in the northwest part of our state. Chesnee has about 2,300 residents and more than 600 are members of the VSP Club, a local Senior Center I have visited several times to exercise with the seniors in our continuing efforts in conjunction with the national You Can Steps to Healthier Aging program sponsored by the Administration on Aging and the Centers for Disease Control. We have held a dozen or more You Can events throughout our state in the last year where we urge seniors to take personal responsibility to improve their health and quality of life. It is really simple and involves making better lifestyle decisions about tobacco, exercise and nutrition. I'll be back there later this month to help Council on Aging Director Nancy Ogle dedicate the new Archibald Rutledge Senior Center in downtown Spartanburg. They have converted the bottom floor of a high-rise senior apartment building into a senior center. Those people in Spartanburg are now talking about working with Medicaid and Medicare to bring home and community based services to seniors served by the Spartanburg Housing Authority. They want to help seniors living in public housing maintain their independence and avoid going into a far more costly nursing home setting. That's the type of forward thinking woven into the President's proposed reauthorization of the Older Americans Act, which was the No. 1 priority of our national White House Conference on Aging. Our country needs its nursing homes. They are a valued health care option, but we simply cannot afford to pay for a nursing home bed for everyone who might need one. So when we find innovation like is occurring in Spartanburg, let's open the gates whenever and wherever we can.

I am told that Dr. Michael Stogner is also here today. I'd like to introduce him in order to say what I just told you is no fluke. Dr. Stogner is the AAA director who not only is involved in the Chesnee/Spartanburg projects but is providing leadership to build South Carolina's third Aging and Disability Resource Center. I was fortunate to help open South Carolina's first one in Aiken 18 months ago. Almost as soon as it opened they found that one-third of their calls were coming from outside their service area. Meantime, in that same area, a marvelous innovation in transportation is being attempted by Lynnda Basham of the AAA. She is working with a multitude of agencies that receive tax dollars to provide transportation to the public. Her idea, funded with seed money from the Administration on Aging and the Centers for Medicare and Medicaid Services, is to harness technology to coordinate all the publicly funded transportation so empty seats can be filled. When we find people trying to turn duplication of effort into services for seniors, let's open these gates whenever and wherever we can.

Down in Charleston, Rev. Dick Giffin, a member of our state's Silver Haired Legislature, is working with community leaders to duplicate the Maine model of an Independent Transportation Network that allows seniors to donate their cars for credit against the cost of future rides. Groups like his need seed money, and the proposed recommendation to

permit cost sharing under the Older Americans Act would open the door for private sector support of this vital service for seniors. This would give greater flexibility to State Units on Aging and Area Agencies on Aging in helping city and county governments prepare for the aging of the baby boomers.

South Carolina has just implemented a new geriatrician loan forgiveness program after we discovered we had only 30 board certified geriatric physicians to treat our 500,000 seniors. We worked with the Silver Haired Legislature, AARP, advocates and many, many more to come up with a plan to attract new geriatricians. It received unanimous approval by the General Assembly. Today, after making our first round of awards, our seniors have eight new doctors specially trained in geriatrics.

One of my first decisions as head of the Office on Aging was to bring together a group of distinguished business leaders and community leaders to serve on my Commission for Aging Research and Evaluation. They were backed up by an equally distinguished group of academics and advocates known as the Coalition for Successful Aging that prepared position papers for the issues South Carolina discussed at its state White House Conference on Aging. Together, these groups helped increase awareness of senior issues in South Carolina, especially within the business community.

One thing I have found everywhere is a willingness to join together to build the future by positioning for the senior boom. I think we all know that the future we build for today's seniors is also our future, and conversely, the future we deny our seniors is the one we lose ourselves.

I said South Carolina was building for the future by positioning for the senior boom. We believe technology, data and research can allow us to make evidence-based decisions to give us the best results as we invest our scarce tax dollars. South Carolina may be unique in its creation of a senior data cube, which links together large data bases so they may be cross referenced. We are early in this process, and have been helped, as always, by creating partnerships and being alert to private sector and foundation funding. Preliminary conclusions are showing a direct correlation between the intensity of OAA services and the avoidance of hospital ER use and in-patient admission. While we can project a cost savings to our state in its Medicaid program, I think there will be tremendous cost savings to the federal government, especially in the Medicare and Medicaid programs. As we talk about reauthorizing the Older Americans Act, perhaps the major message is that while Older Americans Act services are not expensive programs they are the foundation for programs and services that can save tax dollars. From our standpoint, the prevalence of obesity-related conditions such as coronary heart disease, stroke, and diabetes is disproportionately high in South Carolina. One in four adults is obese in our state, and more than three out of five is overweight. We must find ways to prevent obesity and chronic diseases by encouraging the use of evidence-based health promotion and disease prevention programs at the community-level through local aging services provider organizations such as senior centers, nutrition programs, senior housing projects, and faith-based groups. Like I said at the outset, we have begun this process by emphasizing the You Can program.

Your invitation to me to testify today asked for a description of what the State of South Carolina is doing to help older Americans live a more healthy and independent life, and you asked to me to discuss proposed amendments to strengthen programs and services for older Americans administered by the Administration on Aging. I have some

specific recommendations, as well as a genuine endorsement of the reauthorization of the Older Americans Act.

I have specific recommendations in my written remarks, but if it pleases the committee, I will summarize my recommendations.

First, I want to endorse Choices for Independence, the centerpiece of the reauthorization proposal. Not only does Choices give seniors more control, but we have experienced in South Carolina through our waiver, an annual Medicaid cost savings of $1,713 per participant.

Second, we endorse cost sharing. It will allow greater flexibility at the local level and will encourage innovative ways of service delivery.

Third, we recommend the Senior Community Service Employment program be reauthorized. We would ask you to maintain the minimum age of 55 because the sooner we can provide job training skills to help people be independent, the better.

Fourth, we recommend clarification within the nutritional services incentive program and recommend a consolidation of services funded under Part C to reduce unnecessary administrative expense and paperwork.

Fifth, we support increase in Title VII to protect our most vulnerable institutionalized seniors.

Sixth, we do not support designation of a single statewide planning and service area.

Finally, we recommend a technical change regarding grant income, recommending the same language in the regulation be replaced within the act.

In conclusion, I want to thank you, Mr. Chairman, for the opportunity to speak to you today about the reauthorization of the Older Americans Act. I have tremendous respect for and confidence in South Carolina's senior community.

More specifically, I want to endorse Choices for Independence, the centerpiece of the reauthorization proposal for modernizing the Older Americans Act, which will be important to enhancing systems change efforts in South Carolina. The new Choices proposal focuses on the non-Medicaid side of the long term care equation. Many older South Carolinians become Medicaid eligible after spending their lifetime savings on nursing home care. Most prefer to remain at home and in the community as long as possible. If Congress enacts and funds the proposed Choices program, more seniors can receive the community based services needed to prevent or delay the more expensive institutional based care. Choices for Independence will help the non-Medicaid senior population to exercise more control over long term care options, make better use of their own resources, and avoid, or delay, nursing home placement.

South Carolina is facing growing fiscal pressures in our Medicaid budgets. As we note that the baby boom generation will soon be reaching retirement age, we are growing increasingly concerned about how we will meet long term care needs while keeping our Medicaid budgets contained. Helping seniors who are not Medicaid eligible to optimize the use of their own private resources can help them delay, or better yet avoid, spending

down to Medicaid. Expanding the Older Americans Act to provide more choices for community based care and more options for cost sharing has the potential to better serve our seniors and to contain costs for long term care.

In South Carolina we have allowed caregivers served through our Title III-E Family Caregiver Support program to specify what they most need to help them in providing care to a loved one over the age of 60. Experience has shown that the caregivers can make a little bit of money go a long way when they have more control over how it is used. We would welcome the opportunity to test increased consumer control and choice in other OAA services. Currently, most OAA dollars are tied to specific service categories. The Choices proposal would allow the OAA dollars to instead be tied to people's needs.

Within our Medicaid program, South Carolina has documented benefits of consumer choice and control through SC Choice, our Independence Plus Waiver. There was an average annual Medicaid savings of $1,713 per SC Choice participant in the pilot project. After a successful pilot, SC Choice was implemented statewide as of January 2006.

To support informed decision making and to provide comprehensive service information, and with grants from CMS and AoA, we have developed SC Access, a website with information on over 12,000 services. Trained and certified Information and Assistance specialists are available by phone to provide the important human component to the SC Access system.

Through our Aging and Disability Resource Center (ADRC) pilot program, we are working closely with our Medicaid program for long term care services. We now provide support to persons who are placed on the waiting list for the elderly disabled community based services waiver. Identifying persons at high risk of institutional placement who prefer to remain in the community is one step in keeping the Medicaid budget in check. Having more options for long term care services in the community would be an important next step.

Additionally, we would welcome funding for activities that will integrate our three ADRC with statewide public education campaigns to help people begin to plan for their future, like the programs AOA is promoting under the Own Your Future initiative. We will help private pay individuals use low cost community based alternatives, such as adult day care and respite care programs, and utilize private financing options such as private long-term care insurance and home equity instruments.

We strongly endorse cost sharing. Past regulations have tied the hands of service contractors by disallowing cost sharing, for example, in home delivered meal and group dining programs. In these times of diminishing resources, aging organizations must market their programs to a broader spectrum of seniors to obtain needed revenue. This can be expanded through changes in the cost sharing portion of the statute. Seniors that can afford to pay for services should be allowed to contribute to those services. Organizations should then have the flexibility to use those funds where there are waiting lists for services, or to improve current service. We support the AoA proposed changes to the OAA that would permit states to institute cost sharing for all OAA services, except for certain programs that will retain their exemption. The President's New Freedom Initiative has provided a national vision for reforming the long term care system by

empowering consumers and honoring a strong desire to live in a community and to contribute to the community. We support efforts to modernize the Older Americans Act to bring us closer to this vision. The proposed changes will provide opportunities for states to implement a new approach and to evaluate the impact on the health and well-being of older people, their family caregivers, and health care costs. The President's 2007 Budget Request includes resources to begin implementation. We hope to see Congress enact a bill that will include the Choices Initiative. In South Carolina we want to do all we can to provide the highest possible quality of life for all of our seniors. We are proud of what we have done for seniors since the state office on aging moved to the Lt. Governor's Office. We think this legislation will help states prepare to better serve the growing population of seniors and we look forward to working with the Administration on Aging on a new vision for prevention, choice and greater consumer control within the long term care system.

We strongly recommend that the Senior Community Service Employment program be re-authorized with particular emphasis on maintaining two important features of the program. First, maintain the minimum eligibility age at 55 because the sooner we can provide job training skills to help people be independent, the better. Research projects that 9 million seniors will be eligible for SCSEP in 10 years, according to current guidelines with an eligibility age of 55. If SCSEP did not already exist as it has for over 40 years, experts on aging today most likely would be calling for creating a new program just like SCSEP as part of a larger, comprehensive national response to our aging society. Secondly, continue to allow participants to provide community service to their host agency during their training period. Host agencies would be greatly diminished if paid community service were reduced. Among agencies that would be affected are Meals on Wheels, senior centers and elder-care services, as well as rural libraries and One-Stop Career Centers where SCSEP participants often serve as specialists for all older job seekers.

We support provisions under Title V requiring comprehensive study of current and future senior employment needs, including examination of Title V, Workforce Investment Act programs and all federal employment programs. We recommend procedures to coordinate those programs.

We recommend clarification within the nutritional services incentive program. Disbursements of NSIP funds should be made based on the meals reported in the most recent NAPIS report submitted to the Administration on Aging. The current wording requires that funds be distributed based on the meals served in the preceding fiscal year. Since the funds are appropriated in October and the report for the preceding fiscal year is not submitted until January, at the beginning of the grant period the states have no idea how much NSIP revenue will be awarded. The Area Agencies on Aging have contractors who are providing meals with an expectation of reimbursement that may not be met, if the state receives less NSIP than projected. Waiting until the final quarter of the current federal fiscal year to determine the total amount of NSIP for each state does not do what the program intends. Without a firm number to work with, some providers are over expending and others may hold back services that could have been provided if the amount of NSIP revenue was assured at the beginning of the grant period. NSIP funding for October 1, 2006 though September 30, 2007 should be distributed based on the NAPIS report due to the Administration on Aging in January 2006 and not on the report due in January 2007.

We recommend that there be a consolidation of services so that nutritional services are funded as Part C only. This would reduce unnecessary administration and related paperwork. With one authorization and appropriation for Part C, more flexibility would be allowed throughout the grant period, thereby making the program more responsive to consumer needs.

We support increase in authorization of Title VII provisions and services to enhance capacity to increase training of law enforcement and medical staff, broaden public education and community involvement, and facilitate coordination amongst all the professionals and volunteers involved with prevention, intervention, detection investigation and treatment of abuse, neglect and exploitation of vulnerable older adults. Statistics nationwide state 1 in 14 persons report incidences of elder abuse. The OAA under Title VII has a provision for the prevention of abuse, neglect and exploitation of older persons for both community and institutional settings. Limited dollars are allocated to this provision, however we must begin to think of the new population entering the aging sector; baby boomers who have more discretionary dollars. Many of these persons will be targeted for abuse, neglect and/or exploitation. In order to meet the needs of this incoming population, formers of the OAA must examine current and future allocations to adequately provide education and training activities. I would also ask for review for the addition of legal assistance dollars in Title VII. The initial allocation of legal assistance dollars included in Title III are quickly eroded by older persons in the community, thereby leaving few if any dollars for persons in institutions who may need legal representation/assistance. This issue “bubbles over” to areas of Choice, Nursing Home Transition (Home Again), etc. as seniors move throughout the continuum of care.

We recommend this specific action regarding grant income. Several years ago the Office of the Inspector General issued a report that resulted in changes in the use of grant related income. Prior to that report, states operated on the provisions that are still in the official Federal regulations for the Older Americans Act [CFR 45 1321.67(b)(1) and (2)] that allow grant related income to be used as match, to expand services, or both. We recommend that the same language in the regulation cited above replace the language of the Older Americans Act at Section 315 (a)(5)(C) and (b)(4)(E). This would allow AAAs to expand services to areas where there may not be sufficient local sources of revenue to meet the required level of local match. It would also allow local resources to be used for consumer directed services for which there are no Older Americans Act funding.

We do not support the proposed designation of single statewide planning and service areas. The current service delivery and planning structure at the regional level is well established, and is working very well in South Carolina. Current law already provides a process by which individual states can reduce their number of planning and service areas if they so choose, and those states with a single planning and service area were designed that way for specific reasons within those states.